

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

[4478] 58-047292
STATE FILE NUMBER

FILED JAN 5 1959

Registration District No. 325 Primary Registration District No. 4478 Registrar's No.

300
573

1. PLACE OF DEATH a. COUNTY <u>Lancaster</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arkansas</u> b. COUNTY <u>Hot Springs</u>	
b. CITY OR TOWN <u>Lancaster</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>Malvern</u>	8030 4 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Length of stay in 1b	d. STREET ADDRESS <u>104 East Elmo</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Lee</u> Last <u>Warden</u>			4. DATE OF DEATH Month <u>Dec</u> Day <u>5</u> Year <u>58</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-13-34</u>	9. AGE (In years last birthday) <u>24</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	11. BIRTHPLACE (City and state or country) <u>England, Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
--	--	--	--

13a. FATHER'S NAME <u>Lonnie L Warden (Deceased)</u>	13b. MOTHER'S MAIDEN NAME <u>Cora Kisse</u>	14. NAME OF HUSBAND OR WIFE <u>Lina Sue Fulton Warden</u>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>432-10-0923</u>	17. INFORMANT <u>Mrs. Lina Sue F. Warden, Malvern, Ark.</u>	Address
---	---	--	---------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Found Dead</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Autopsy performed at</u>	
	DUE TO (c) <u>Medical Center Little Rock Ark</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>892646</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>ITEM 20a, 20c, 20e CORRECTED</u>
20c. TIME OF INJURY Hour Month, Day, Year a.m. <u>Dec. 5, 1958</u> p.m.	BY AFFIDAVIT OF <u>Coroner</u> <u>1-20-59 DCB</u>

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Bunkhouse</u>	20f. CITY, TOWN, OR LOCATION <u>Lancaster</u>	COUNTY <u>Schuler</u>	STATE <u>Mo</u>
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE <u>Bruce W. Norman</u>	(Degree or title) <u>Coroner</u>	22b. ADDRESS <u>Lancaster, Mo.</u>	22c. DATE SIGNED <u>Dec 30 58</u>
--	-------------------------------------	---------------------------------------	--------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-8-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Philadelphia</u>	23d. LOCATION (City, town, or county) (State) <u>Near Sheridan, Arkansas</u>
--	-----------------------------	---	---

24. FUNERAL DIRECTOR <u>Drummond Funeral Home, 901 Marshall Little Rock, Arkansas</u>	25. DATE RECD. BY LOCAL REG. <u>12-30-58</u>	26. REGISTRAR'S SIGNATURE <u>Bruce W. Norman</u>
--	---	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

JAN 20 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
[Handwritten Signature]

Licensed Embalmer No. 3725-1

P. O. Address _____
[Handwritten Address]

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.